		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0021394

Facility Name: BIG MEADOWS

Address: 1000 LONGMOOR (Number) SAVANNA (City) 61074 (Zip Code)

County: CARROPLL

Telephone Number: 815-273-2238 **Fax #** 815-273-7294

IDPA ID Number: 362819435001

Date of Initial License for Current Owners: 10/21/76

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ALAN GAPINSKI **Telephone Number:** 815-778-3683

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) ALAN GAPINSKI
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	122	Intermediate (ICF)	122	44,530	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	122	TOTALS	122	44,530	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	20,400	11,431		31,831	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,400	11,431		31,831	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.48%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/11/76

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/15/78 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	173,055	18,235	5,810	197,100	1,043	198,143		198,143			1
2	Food Purchase		191,901		191,901		191,901	(4,708)	187,193			2
3	Housekeeping	71,101	15,917		87,018	227	87,245		87,245			3
4	Laundry	58,545	14,924		73,469	227	73,696	(5,311)	68,385			4
5	Heat and Other Utilities			87,987	87,987		87,987	(8,409)	79,578			5
6	Maintenance	45,442	25,064	12,081	82,587		82,587		82,587			6
7	Other (specify):*											7
8	**TOTAL General Services**	348,143	266,041	105,878	720,062	1,497	721,559	(18,428)	703,131			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	845,469	70,550	4,106	920,125	(11,515)	908,610		908,610			10
10a	Therapy	12,733	1,160	10,246	24,139		24,139		24,139			10a
11	Activities	58,708	7,250	3,075	69,033		69,033		69,033			11
12	Social Services	44,383			44,383		44,383		44,383			12
13	Nurse Aide Training			4,296	4,296	13,192	17,488		17,488			13
14	Program Transportation	15,285	4,058		19,343	(1,911)	17,432		17,432			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	976,578	83,018	21,723	1,081,319	(234)	1,081,085		1,081,085			16
	C. General Administration											
17	Administrative			123,547	123,547		123,547	(17,666)	105,881			17
18	Directors Fees											18
19	Professional Services			9,711	9,711		9,711	7	9,718			19
20	Dues, Fees, Subscriptions & Promotions			20,747	20,747		20,747	(7,690)	13,057			20
21	Clerical & General Office Expenses	66,429	15,939	17,149	99,517		99,517	2,582	102,099			21
22	Employee Benefits & Payroll Taxes			174,765	174,765	(3,174)	171,591	19,068	190,659			22
23	Inservice Training & Education			1,367	1,367		1,367		1,367			23
24	Travel and Seminar			5,805	5,805		5,805	658	6,463			24
25	Other Admin. Staff Transportation							726	726			25
26	Insurance-Prop.Liab.Malpractice			22,679	22,679		22,679		22,679			26
27	Other (specify):* SALES TAX			738	738		738	(738)				27
28	**TOTAL General Administration**	66,429	15,939	376,508	458,876	(3,174)	455,702	(3,053)	452,649			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,391,150	364,998	504,109	2,260,257	(1,911)	2,258,346	(21,481)	2,236,865			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BIG MEADOWS #0021394 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			91,933	91,933		91,933	78,775	170,708			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,081	26,081		26,081	157,491	183,572			32
33	Real Estate Taxes			33,975	33,975		33,975	(1,685)	32,290			33
34	Rent-Facility & Grounds			294,854	294,854		294,854	(295,334)	(480)			34
35	Rent-Equipment & Vehicles			6,000	6,000	(261)	5,739		5,739			35
36	Other (specify):*											36
37	**TOTAL Ownership**			452,843	452,843	(261)	452,582	(60,753)	391,829			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					2,172	2,172		2,172			38
39	Ancillary Service Centers		8,022		8,022		8,022		8,022			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,978	66,978		66,978		66,978			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		8,022	66,978	75,000	2,172	77,172		77,172			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,391,150	373,020	1,023,930	2,788,100		2,788,100	(82,234)	2,705,866			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,708)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,409)	5		5
6	Rented Facility Space	(480)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(5,311)	4		8
9	Non-Straightline Depreciation	(2,553)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(738)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,500)	19		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,151)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(263)	20		28
29	Other-Attach Schedule SEE ATTACHED	(2,890)	21,24		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (35,003)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(47,232)	MISC	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (47,232)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (82,235)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	X		$ 2,172	14,38	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 2,172		47

STATE OF ILLINOIS

BIG MEADOWS

ID# 0021394

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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42				42
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67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,708)	0	0	0	0	0	0	0	0	0	0	(4,708)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(5,311)	0	0	0	0	0	0	0	0	0	0	(5,311)	4
5	Heat and Other Utilities	(8,409)	0	0	0	0	0	0	0	0	0	0	(8,409)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(18,428)	0	0	0	0	0	0	0	0	0	0	(18,428)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(17,666)	0	0	0	0	0	0	0	0	0	(17,666)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,500)	1,507	0	0	0	0	0	0	0	0	0	7	19
20	Fees, Subscriptions & Promotions	(8,414)	723	0	0	0	0	0	0	0	0	0	(7,691)	20
21	Clerical & General Office Expenses	(924)	3,506	0	0	0	0	0	0	0	0	0	2,582	21
22	Employee Benefits & Payroll Taxes	0	19,068	0	0	0	0	0	0	0	0	0	19,068	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(281)	939	0	0	0	0	0	0	0	0	0	658	24
25	Other Admin. Staff Transportation	0	726	0	0	0	0	0	0	0	0	0	726	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(738)	0	0	0	0	0	0	0	0	0	0	(738)	27
28	**TOTAL General Administration**	(11,857)	8,803	0	0	0	0	0	0	0	0	0	(3,054)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(30,285)	8,803	0	0	0	0	0	0	0	0	0	(21,482)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **BIG MEADOWS** **# 0021394** **Report Period Beginning:** **01/01/00** **Ending:** **12/31/00**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(2,553)	81,328	0	0	0	0	0	0	0	0	0	78,775	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	157,491	0	0	0	0	0	0	0	0	0	157,491	32
33	Real Estate Taxes	(1,685)		0	0	0	0	0	0	0	0	0	(1,685)	33
34	Rent-Facility & Grounds	(480)	(294,854)	0	0	0	0	0	0	0	0	0	(295,334)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,718)	(56,035)	0	0	0	0	0	0	0	0	0	(60,753)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(35,003)	(47,232)	0	0	0	0	0	0	0	0	0	(82,235)	45

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
AMERICAN HEALTH	100.00%	PLEASANT VIEW	MORRISON			
ENTERPRISES,INC.						
MANAGEMENT ONLY	0.00%	WINNING WHEELS,INC.	PROPHETSTOWN			
	0.00%	STRIVE	PROPHETSTOWN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		34	RENT	$ 294,854	VINCENT & NORMA ARIOSO	100.00%	$	$ (294,854)	1
2	V		30	DEPRECIATION				77,899	77,899	2
3	V		32	MORTGAGE				139,222	139,222	3
4	V		32	MORTGAGE				16,419	16,419	4
5	V		17	HOME OFFICE	123,547	AMERICAN HEALTH ENTERPRISE,INC.	100.00%	137,629	14,082	5
6	V					OPERATING COMPANY				6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 418,401			$ 371,169	$ * (47,232)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	AMERICAN HEALTH				MANAGEMENT FEES				$		1
2	ENTERPRISES,INC.										2
3	ALAN GAPINSKI	PRESIDENT	DIRECT	100.00%							3
4			MANAGEMENT								4
5	BIG MEADOWS, INC.			100.00%	28,398	14	28.00	MANAGEMENT	123,547	17,3	5
6	PLEASANT VIEW			100.00%	20,285	10	20.00	FEES	84,533	N/A	6
7	WINNING WHEELS,INC.			0.00%	36,512	18	36.00	"	153,500	N/A	7
8	STRIVE			0.00%	10,142	5	10.00	"	93,500	N/A	8
9	OTHER (NON-COST REPORT)			0.00%	6,085	3	6.00	"	84,000	N/A	9
10											10
11											11
12											12
13								TOTAL	$ 539,080		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: AMERICAN HEALTH ENTERPRISES,INC.
Street Address: 501-6TH AVE. WEST
City / State / Zip Code: LYNDON, IL. 61261
Phone Number: (815-778-3683
Fax Number: (815-778-4503

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	DIRECT COST	1	1	$ 48,682	$ 48,682	1	$ 48,682	1
2	17	ADMINISTRATIVE	GROSS REVENUE	10,183,200	5	214,152	214,152	2,719,900	57,199	2
3	19	DATA PROCESSING	GROSS REVENUE	10,183,200	5	3,958	0	2,719,900	1,057	3
4	19	ACCOUNTING FEES	DIRECT COST	2	2	900	0	1	450	4
5	20	DUES,FEES,SUBSCRIPTIONS	GROSS REVENUE	10,183,200	5	1,618	0	2,719,900	432	5
6	20	RECRUITMENT	GROSS REVENUE	10,183,200	5	1,090	0	2,719,900	291	6
7	21	SUPPLIES, PHONE	GROSS REVENUE	10,183,200	5	13,125	0	2,719,900	3,506	7
8	22	BENEFITS	DIRECT + % INDIRECT	429,478	5	71,623	0	81,886	19,068	8
9	24	TRAINING,SEMINARS	GROSS REVENUE	10,183,200	5	3,517	0	2,719,900	939	9
10	25	ADMIN. TRANSPORTATION	GROSS REVENUE	10,183,200	5	2,717	0	2,719,900	726	10
11	30	DEPR'N. VEHICLES	GROSS REVENUE	10,183,200	5	7,990	0	2,719,900	2,134	11
12	30	DEPR'N. EQUIPMENT	GROSS REVENUE	10,183,200	5	4,849	0	2,719,900	1,295	12
13	32	INTEREST (VEHICLES)	GROSS REVENUE	10,183,200	5	606	0	2,719,900	162	13
14	32	INTEREST (WORKING CAP)	DIRECT COST	2	2	3,375	0	1	1,688	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 378,202	$ 262,834		$ 137,629	25

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	MORTGAGE SEE SCHVII2		X	MORTGAGE	$18,262.00		$	$ 1,498,556		9.00%	$ 139,222	1
2	MORTGAGE SEE SCH VII2		X	MORTGAGE	$3,040.00			161,444		9.00%	16,419	2
3												3
4												4
5												5
	Working Capital											
6	FIRST IL NATIONAL BANK		X	WORKING CAPITAL	$5,190.00		229,765	90,683		9.00%	10,289	6
7	VINCENT ARIOSO	X		WORKING CAPITAL	NONE		197,389	197,389	DEMAND	8.00%	15,792	7
8	CORPORATE ALLOCATION	X		WORKING CAPITAL/AUTOS	$627.00		25,000	25,000	DEMAND	9.00%	1,850	8
9	TOTAL Facility Related				$27,119.00		$ 452,154	$ 1,973,072			$ 183,572	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 452,154	$ 1,973,072			$ 183,572	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BIG MEADOWS **#** 0021394 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	11,391	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	36,014	2
3. Under or (over) accrual (line 2 minus line 1).	$	24,623	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	7,667	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	32,290	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	31,220	8
	1996	31,530	9
	1997	36,469	10
	1998	39,930	11
	1999	36,014	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,835 B. General Construction Type: Exterior BRICK Frame CEMENT BLOCK Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY GROUMDS	13 ACRES	1985	$ 25,000	1
2					2
3	TOTALS	#VALUE!		$ 25,000	3

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	122			1968	$ 1,249,665	$ 66,232	19	$ 66,232	$	$ 1,007,226	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	HANDRAILS			1976	200		10			200	9
10	REMODELING			1976	7,068		10			7,068	10
11	EMERGENCY PANELS			1976	2,913		7			2,913	11
12	FIRE SYSTEM			1976	12,487		10			12,487	12
13	PANIC DEVICE			1977	397		7			397	13
14	PLUMBING FIXTURES			1977	2,900		7			2,900	14
15	EMERGECY LIGHTS			1977	397		7			397	15
16	TV ANTENNA SYSTEM			1977	290		7			290	16
17	DRAINAGE DITCH			1977	2,474		10			2,474	17
18	WHEEL CHAIR RAMPS			1977	764		7			764	18
19	TRANSFER SWITCH			1977	472		7			472	19
20	RENOVATE NURSING			1977	14,707		7			14,707	20
21	PLUMBING			1977	149		7			149	21
22	STORM WINDOWS			1978	529		7			529	22
23	STORM WINDOWS			1979	831		10			831	23
24	SEAL COAT			1979	832		5			832	24
25	3 FIRE DOORS			1980	173		10			173	25
26	LAUNDRY IMPROVEMENTS			1980	8,606		10			8,606	26
27	FIRE PARTITIONS			1980	2,972		5			2,972	27
28	STORM WINDOWS			1980	416		7			416	28
29	FIRE SYSTEM			1980	1,116		10			1,116	29
30	STORM WINDOWS			1982	416		10			416	30
31	BLACKTOP			1983	15,505		5			15,505	31
32	BLACKTOP			1984	9,950		10			9,950	32
33	GARAGE			1984	7,616	423	18	423		6,804	33
34	CARPET OFFICE & LOUNGE			1985	1,650		5			1,650	34
35	WALL TRAX/82 BATHROOMS			1985	2,025		10			2,025	35
36	TOTAL (lines 4 thru 35)				$ 1,347,520	$ 66,655		$ 66,655	$	$ 1,104,269	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BLINDS			1985	548		5			548	9
10	2 HEATING/ AC UNITS			1985	4,000		10			4,000	10
11	DRAPES/HEATING & AC UNITS			1986	9,511		10			9,511	11
12	PARKING LOT SEAL COATING			1986	4,760		10			4,760	12
13	INSULATE EXTERIOR WALLS			1985	5,368		10			5,368	13
14	SKYLIGHT ROOFING			1990	4,000		5			4,000	14
15	CARPETING			1990	4,045		5			4,045	15
16	REMODELING			1990	38,775	1,939	20	1,939		20,036	16
17	FLOORING NURSING STATION			1991	1,833	92	20	92		910	17
18	FIRE /SMOKE DETECTORS			1991	2,022	135	15	135		1,304	18
19	COMPRESSOR			1991	1,275	127	10	127		1,232	19
20	HANDRAILS			1991	1,959	131	15	131		1,253	20
21	ROOF			1991	62,500	3,125	20	3,125		29,687	21
22	AIR EXCHANGERS			1991	3,115	208	15	208		1,931	22
23	AIR CONDITIONER			1991	1,987	132	15	132		1,246	23
24	CHILLER			1991	1,678	112	15	112		1,045	24
25	VINYL FLOORING			1992	375	25	15	25		208	25
26	AUTO DOOR LOCKS			1992	3,344	334	10	334		2,757	26
27	BATH ROOM FLOORING			1993	1,925	128	15	128		1,025	27
28	WALLPAPER			1993	1,332		7			1,331	28
29	RFT ANTENNA			1993	396	40	10	40		315	29
30	AIR CONDITIONER			1994	22,365	1,491	15	1,491		9,816	30
31	SUMP PUMP			1994	8,239	824	10	824		5,150	31
32	REMODELING			1995	267,241	15,055	20	13,362	(1,693)	68,328	32
33	FENCE/COURTYARD EQUIPMENT			1995	1,945	144	5	144		1,945	33
34	WATER SOFTENER			1995	9,100	910	10	910		4,626	34
35	BOILER			1995	18,575	929	20	929		4,722	35
36	TOTAL (lines 4 thru 35)				$ 482,213	$ 25,881		$ 24,188	$ (1,693)	$ 191,099	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CODE ALERT DOOR ALARM			1995	13,664	1,366	10	1,366		6,944	9
10	100 ACCORDIAN DOORS			1996	47,210	3,147	15	3,147		15,473	10
11	SMOKE DETECTORS			1996	4,941	329	15	329		1,618	11
12	HOPPERS			1996	2,467	247	10	247		1,214	12
13	SKYLIGHTS			1996	2,520	504	5	504		2,478	13
14	LIGHTS			1996	7,088	709	10	709		3,309	14
15	CABINETS			1996	3,216	214	15	214		999	15
16	LANDSCAPING			1996	1,806	181	10	181		844	16
17	TABS MONITOR			1996	667	95	7	95		428	17
18	AIR CONDITIONER COMPRESSOR			1996	3,160	211	15	211		932	18
19	WINDOWS & GUTTERS			1996	3,200	213	15	213		941	19
20	COVE BASE			1996	1,009	67	15	67		290	20
21	REMODELING			1996	600	60	10		(60)	0	21
22	PAINT & WALLPAPER			1996	20,197	4,385	7	2,885	(1,500)	15,925	22
23	FLOORING			1996	66,389	3,726	15	4,426	700	21,430	23
24	ELECTRICAL			1996	5,438	363	15	363		1,815	24
25	PLUMBING			1996	7,900	790	10	790		3,950	25
26	PAINT SKYLIGHTS			1997	4,493	642	7	642		2,247	26
27	QUARRY TILE FLOOR			1997	1,555	104	15	104		407	27
28	NURSE CALL UNITS			1997	3,237	216	15	216		684	28
29	MOTOR & BEARING ASSBLY FOR HEAT PUMPS			1998	2,979	425	7	425		1,063	29
30	REPAIR PASSENGER ELEVATOR			1998	2,935	147	20	147		416	30
31	WATER HEATER & STORAGE TANK			1998	4,605	658	7	658		1,645	31
32	3 STEEL DOORS			1998	2,458	123	20	123		338	32
33	7.5 TON AIR CONDITIONER			1999	10,376	1,038	10	1,038		1,557	33
34	WALK IN COOLER			1999	7,831	783	10	783		1,175	34
35	CONCRETE			1999	607	61	10	61		91	35
36	TOTAL (lines 4 thru 35)				$ 232,548	$ 20,804		$ 19,944	$ (860)	$ 88,213	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PAINTING			1999	8,818	1,260	7	1,260		1,890	9
10	CARPETING			1999	9,079	1,297	7	1,297		1,945	10
11	HVAC UNITS IN EACH ROOM			2000	61,122	3,056	10	3,056		3,056	11
12	PAVING PARKING LOTS PLUS STRIPPING			2000	29,145	1,457	10	1,457		1,457	12
13	WINDOWS FOR PATIENTS ROOMS & OFFICE			2000	69,901	466	25	466		466	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 178,065	$ 7,536		$ 7,536	$	$ 8,814	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 363,011	$ 42,534	$ 42,534	$	VARIOUS	$ 194,405	37
38	Current Year Purchases	7,060	582	582		VARIOUS	582	38
39	Fully Depreciated Assets	221,343					221,343	39
40	HOME OFFICE		1,295	1,295				40
41	TOTALS	$ 591,414	$ 44,411	$ 44,411	$		$ 416,330	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	SNOW PLOWING/MAINT	CHEVROLET TRUCK 98	1997	$ 29,205	$ 5,841	$ 5,841	$	5	$ 20,444	42
43	HOME OFFICE VEHICLE									43
44	ALLOCATION				2,134	2,134				44
45										45
46	TOTALS			$ 29,205	$ 7,975	$ 7,975	$		$ 20,444	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,885,965	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 173,262	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 170,709	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (2,553)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,829,169	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	CABLEVISION	$ 700	$	$ 700	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 700	$	$ 700	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: VINCENT & NORMA ARIOSO

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1967,68	122	01/01/95	$ 294,854	20		3
4	Additions							4
5								5
6								6
7	TOTAL		122		$ 294,854 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: AFTER 2005,$2400000 *

10. Effective dates of current rental agreement:
Beginning 01/01/95
Ending 12/31/14

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2001	$ 293,300
13.	12/31/2002	$ 293,300
14.	12/31/2003	$ 293,300

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	TRANSPORTATION	1996 VAN	$ 500.00	$ 6,000	17
18					18
19					19
20					20
21	TOTAL		$ 500.00	$ 6,000	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 96

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 48

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies				80	80
3	Classroom Wages	(a)	2,162	7,353		9,515
4	Clinical Wages	(b)		3,677		3,677
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments				4,191	4,191
8	Nurse Aide Competency Tests				25	25
9	TOTALS		$ 2,162	$ 11,030	$ 4,296	$ 17,488
10	SUM OF line 9, col. 1 and 2	(e)	$ 13,192			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ NONE

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	11
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	13

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (473)	$ 4,459	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 43,765)	197,918	424,012	3
4	Supply Inventory (priced at)	45,711	76,756	4
5	Short-Term Investments			5
6	Prepaid Insurance		24,585	6
7	Other Prepaid Expenses		355	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): SEE ATTACHED	100,790	100,790	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 343,946	$ 630,957	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	4,292	4,292	11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	741,803	913,683	15
16	Equipment, at Historical Cost	619,602	766,959	16
17	Accumulated Depreciation (book methods)	(775,812)	(860,465)	17
18	Deferred Charges		123,738	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 589,885	$ 948,207	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 933,831	$ 1,579,164	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 356,218	$ 470,760	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	10,380	68,604	29
30	Accrued Salaries Payable	30,792	55,143	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,275	31,231	31
32	Accrued Real Estate Taxes(Sch.IX-B)	7,667	45,487	32
33	Accrued Interest Payable	9,183	12,652	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	OTHER(SEE ATTACHED)	(4,038)	(10,075)	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 428,477	$ 673,802	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	80,303	435,590	39
40	Mortgage Payable	197,389	330,313	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DEFERRED TAXES	3,006	3,006	43
44	OTHER (SEE ATTACHED)	2,135	223,076	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 282,833	$ 991,985	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 711,310	$ 1,665,787	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 222,521	$ (86,623)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 933,831	$ 1,579,164	48

***(See instructions.)**

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 232,593	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 232,593	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(10,073)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (10,073)	17	
	B. Transfers (Itemize):			
18	ROUNDING	1	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 1	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 222,521	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,725,976	1
2	Discounts and Allowances for all Levels	(12,000)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,713,976	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,600	6
7	Oxygen	27,492	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 33,092	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	7,286	11
12	Gift and Coffee Shop	716	12
13	Barber and Beauty Care	1,204	13
14	Non-Patient Meals	4,708	14
15	Telephone, Television and Radio	7,541	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	5,311	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 26,766	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	2,172	28
28a	AIR CONDITIONING & MISC	2,021	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,193	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,778,027	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	720,062	31
32	Health Care	1,081,319	32
33	General Administration	458,876	33
	B. Capital Expense		
34	Ownership	452,843	34
	C. Ancillary Expense		
35	Special Cost Centers	8,022	35
36	Provider Participation Fee	66,978	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,788,100	40
41	**Income before Income Taxes (line 30 minus line 40)****	(10,073)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (10,073)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,148	2,352	$ 55,010	$ 23.39	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,517	8,026	130,100	16.21	3
4	Licensed Practical Nurses	11,709	12,321	156,611	12.71	4
5	Nurse Aides & Orderlies	59,737	62,681	470,107	7.50	5
6	Nurse Aide Trainees	1,954	1,954	13,192	6.75	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,880	2,096	27,342	13.04	9
10	Activity Assistants	4,096	4,255	31,366	7.37	10
11	Social Service Workers	3,451	3,749	44,383	11.84	11
12	Dietician					12
13	Food Service Supervisor	1,872	2,016	20,499	10.17	13
14	Head Cook	2,245	2,468	19,852	8.04	14
15	Cook Helpers/Assistants	21,178	22,087	132,704	6.01	15
16	Dishwashers					16
17	Maintenance Workers	5,049	5,327	45,442	8.53	17
18	Housekeepers	10,672	11,321	71,101	6.28	18
19	Laundry	9,093	9,602	58,545	6.10	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,866	2,018	22,800	11.30	23
24	Clerical	4,992	5,303	43,629	8.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,528	2,795	20,449	7.32	31
32	Other Health Care(specify)					32
33	Other(specify) SEE ATTACHED	3,145	3,472	28,018	8.07	33
34	TOTAL (lines 1 - 33)	155,132	163,843	$ 1,391,150 *	$ 8.49	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	145	$ 5,810	1/3	35
36	Medical Director	41	4,106	9/3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	1,800	10/3	39
40	Physical Therapy Consultant	62	3,075	10a/3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	284	$ 14,791		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	308	$ 4,992	10/3	50
51	Licensed Practical Nurses	116	3,433	10/3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	424	$ 8,425		53

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
GLEN BLACKLOCK	ADMINISTRATOR	0.00%	$ 48,682
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 48,682

B. Administrative - Other

Description	Amount
AMERICAN HEALTH ENTERPRISES,INC.	$ 123,547
TOTAL (agree to Schedule V, line 17, col. 3)	$ 123,547
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CREATIVE SOLUTIONS	MEDICAL RECORDS	$ 2,948
UNISOFT	DIETARY SUPPORT	1,224
COMPUTER INTERGRATION	WEB SITE HOSTING	623
ESSEX	INTERNET SERVICE	300
ACHIEVE	SOFTWARE MAINTENANCE	2,295
ADT	SECURITY SERVICE	352
JANIS CARD CPA	ACCOUNTING	300
B-K APPRAISAL	APPRAISAL	1,500
WARD MURRAY PACE &		
JOHNSON	LEGAL	169
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 9,711

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,055
Unemployment Compensation Insurance	11,253
FICA Taxes	100,350
Employee Health Insurance	8,893
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
RETIREMENT	6,775
PHYSICALS	5,283
PERFECT ATTENDANCE AWARDS	2,583
CHRISTMAS PARTY	970
5 & 10 YEAR BANQUET	1,428
EMPLOYEE RECOGNITION	5,001
CORPORATE ALLOCATION	19,068
TOTAL (agree to Schedule V, line 22, col.8)	$ 190,659

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,080
Health Care Worker Background Check	1,100
(Indicate # of checks performed 157)	
DUES & SUBSCIPTIONS	7,019
ADVERTISING	8,151
OTHER LICENSE	135
YELLOW PAGE ADVERTISING	263
CORPORATE ALLOCATION	723
Less: Public Relations Expense	( )
Non-allowable advertising	(8,151)
Yellow page advertising	(263)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,057

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 281
In-State Travel	
LISTING ATTACHED	5,524
CORPORATE ALLOCATION	939
Seminar Expense	
LESS OUT OF STATE TRAVEL	(281)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,463

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BIG MEADOWS **#** 0021394 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILLINOIS HEALTH CARE ASSO.$4539

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 14,329 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 66,978
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ NONE Has any meal income been offset against related costs? YES Indicate the amount. $ 4,708

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ NONE

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.